Proposed Benefit Summary

605299 CSAC EIA - SAN BENITO COUNTY
KPSA
Member Services 800-443-0815

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/18—12/31/18)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$10 per visit
Urgent care consultations, evaluations, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Most generic refills through our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply

(continues)

Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply, $40 for a 31- to 60-day supply, or $60 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$20 for up to a 30-day supply or $40 for a 31- to 100-day supply

Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit

Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge

Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $175 Allowance
Hearing aid(s) every 36 months	Amount in excess of $500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Ostomy and urological supplies	No charge

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For more information, please refer to the *Summary of Benefits* booklet enclosed.